NEBULIZER/PULMO-AIDE QUESTIONNAIRE

(TO BE COMPLETED BY A PHYSICIAN)

Patient Name	Medi-Cal Number:	Date of Birth:
Provider Name and Address		Provider I.D. Number
		Phone Number
Diagnosis (Specific – Complete)		
Date of onset: Severity:	Length of need:	
Dates for past 12 months for above diagnosis: Acute Hospital Admits: _____ ER/Urgent Clinic Visits: _____ Office Visits (Attach Office Notes): _____		
Have metered dose inhalers been utilized _____ Type: _____ If Yes, Results: _____ If No, Why: _____		
Present Medications (Type and Dose):		
Indicate evidence of clinical benefit from this alternate method of medication delivery:		
Why not drug aerosolized chamber attachment to metered inhalers:		
Physician's Signature	Date	
Physician's Name (Please Print) Address	License Number	
Address	Phone Number	